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# **Religion, Spirituality and Mental Health: response from the Executive Committee of the Spirituality and Psychiatry Special Interest Group<sup>1</sup>**

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## **Abstract**

Research demonstrates important associations between religiosity and wellbeing. Spirituality and religious faith are important coping mechanisms for managing stressful life events. Despite this, there is a “religiosity gap” between mental health clinicians and their patients. The former are less likely to be religious and recent correspondence in the *Bulletin* suggests that some at least do not consider it appropriate to encourage discussion of any spiritual or religious concerns with patients. However, it is difficult to see how failure to discuss such matters can be consistent with the objective of gaining a full understanding of the patient’s condition and their self-understanding, or attracting their full and active engagement with services.

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<sup>1</sup> *This response has been prepared by the authors on behalf of the Executive Committee of the Spirituality and Psychiatry Special Interest Group*

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In his recent editorial in the *Psychiatric Bulletin*, Koenig (1) makes several important points concerning religion and mental health. Research demonstrates largely positive associations between religiosity and wellbeing (2). Additionally, religion is a prevalent coping strategy in those experiencing adverse life events (3).

The Spirituality and Psychiatry Special Interest Group holds the view that psychiatrists should respect their patients' religious and spiritual beliefs, and that these beliefs should be given thoughtful and serious consideration in the clinical setting. It is time to move away from the old tendency to see religious and spiritual experience as pathology towards an appreciation of how religion and spirituality can be conducive to mental health.

A 'religiosity' gap has been frequently pointed out in empirical studies – most psychiatrists are less religious than their patients and neglect religious issues in clinical assessment (4, 5). However, there is some evidence that the situation may be changing; psychiatrists in the USA do now regularly enquire about patients' spiritual and religious beliefs (6), an approach that is strongly endorsed by the Executive of this Special Interest Group. We hold that it is important to understand the role that spirituality and religion play in people's lives; not simply the fact that such beliefs are held but the ways in which individuals appeal to those beliefs when under stress. Taking a spiritual history is, therefore, important in understanding an individual's coping strategies, as well as identifying the potential for conflict with recommended treatments.

Patients with religious beliefs may be extremely reluctant to engage with psychiatric services that they perceive to be atheistic, scientific and disparaging of religion (7). For example the Ultra-Orthodox Hasidic Jewish community in London treat psychiatry and psychology with great suspicion and are generally reluctant to attend psychiatric consultations for fear of misdiagnosis (8). How to engage religious groups in mainstream psychiatric services and the problems which they encounter during assessment and treatment should be a focus for future research. The use of culture brokers (key representatives of cultural groups) to mediate between religious communities and mental health services remains under-researched.

Recent mental health literature differentiates religion from spirituality (9). The former usually refers to socially based beliefs and traditions, often associated with ritual and ceremony, while spirituality generally refers to a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater 'whole', together with a sense of belonging and acceptance. Spirituality is expressed through art, poetry and myth, as well as religious practice. Both religion and spirituality typically emphasise the depth of meaning and purpose in life. One does not, of course, have to be religious for life to be deeply meaningful, as atheists will avow. Yet while some atheists might not consider themselves spiritual, many do. Spirituality is thus a more inclusive concept than religion.

The idea that illness, both physical and mental, can bring a crisis of meaning is not new. All sickness of any severity shatters the taken-for-granted perspective on life and necessitates some form of explanation and interpretation. Much of the writing in medical anthropology emphasises a meaning-centred approach (10). This point is central to the concept of recovery in mental health (11). For example, it is not enough to ask about voices. What is also important is how hearing voices influences a person's life, how he/she makes sense of the experience and how might he/she best cope with the voices. Every psychiatric assessment should be far more than a symptom inventory; it needs to be, wherever possible, an enquiry into meaning.

On the other hand, the issue of praying with patients will always be contentious. For certain patients, this might be helpful and could potentially strengthen the therapeutic alliance. However, we advocate extreme caution (as does Koenig) in responding to a patient's request to join with him/her in prayer; either way, the response calls for great sensitivity. The issue of prayer (and the use of religious/spiritual healing generally) raises significant issues about boundaries, the role of the psychiatrist and the ethics of self-disclosure. Where should the line be drawn? If a psychiatrist prays with his/her patients, could it be argued that he/she should be willing to read the Bible or other sacred texts with them, in order to quote passages that are felt to be healing? Again, this proposition will raise significant ethical dilemmas.

Koenig is correct in mentioning referral to clergy. We emphasise that this should always be a two-way process, with detailed communication occurring on both sides. There is much that mental health professionals can learn from chaplaincy - a term used here to denote all faiths - and similarly there is a need for chaplains (who are often the first port of call for those with mental disorders) to be knowledgeable about mental health issues. The question arises as to how these two groups could best learn from each other.

The correspondence following Koenig's editorial has raised a number of concerns. Some professionals view taking a spiritual history as potentially 'intrusive', holding that spiritual and religious concerns go beyond the brief of the psychiatrist, and seeing prayer as a 'non-clinical' activity that blurs boundaries and creates ambiguity (12). It has been argued that the practices recommended by Koenig are not evidence-based (13). Concerns have also been raised about the place of religion in delusional systems and that religious physicians may be less likely to seek psychiatric help for their patients (14). These kinds of concern have reinforced some service users' perceptions of antipathy within psychiatry towards spirituality and religion. However, they also suggest that there is need for much more debate about the research evidence, ethical boundaries and the professional practices that govern the relationship between spirituality and psychiatry.

The Spirituality and Psychiatry Special Interest Group continues to highlight the need for all mental health professionals to be sensitive to spirituality, culture and religion. Psychiatrists need to understand how religion and spirituality affect their patients' lives in illness as well as health, and how

spiritual and religious values can be harnessed to facilitate the healing process (15). The burgeoning interest in this field, from within the profession and from service users alike, supports our view that an understanding of the relationship of spirituality and religion to mental health, far from being an optional extra, should be counted as essential to good clinical practice.

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